HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Postpartum Haemorrhage Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer

Purpose

The purpose of this policy is to provide safe and effective care to women who experience a postpartum haemorrhage. Postpartum haemorrhage is one of the leading causes of maternal death and morbidity.

The principles of care are:

- Effective multiprofessional communication and teamwork.
- Risk assessment and targeted prevention in the antenatal period.
- Prompt identification and correction of the cause of the PPH.
- Assess severity of blood loss and tailor management and monitoring appropriately
- Early resuscitation

Scope

- All obstetric and midwifery staff employed by Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders.
- Anaesthetic staff

Abbreviations used in this document

EUA	Examination under anaesthetic
LSCS	Lower segment caesarean section
PPH	Postpartum haemorrhage
IDC	Indwelling catheter
CBC	Complete blood count
MEOWS	Modified Early Obstetric Warning Score

Definitions

Traditionally PPH has been defined as a blood loss of 500ml or more during puerperium and severe PPH as a blood loss of 1000ml or more. Further classification of PPH into primary (within 24 hours of birth) and secondary (between 24 hours and six weeks postpartum)

Massive obstetric haemorrhage

Arbitrarily this is set at estimated blood loss in excess of 1500 ml and ongoing and is a life threatening event (Ministry of Health, 2013).

Risk factors for PPH

Some of the risk factors are conditions for which a LMC Midwife recommends to the woman that a referral, consultation or transfer of clinical responsibility takes place (Ministry of Health, 2012).

- Previous PPH. *Referral offered in the ante natal period (Code 3013). Care plan documented in clinical records.*
- Multiple pregnancy. *Referral offered in the ante natal period (Code 4018). Care plan documented in clinical records.*
- Induction and augmentation of labour.
- Previous LSCS and any other uterine surgery. *Referral offered in the ante natal period (Code 2007). Care plan documented in clinical records.*
- Prolonged labour *Referral offered during labour. (Code 5021 first stage and Code 5023 active second stage). Care plan documented in clinical records.*
- Precipitate labour
- Known or suspected abnormal placentation i.e. accreta, percreta, *Care plan documented in the clinical records.*
- Instrumental vaginal delivery
- Tears and lacerations
- Antepartum Haemorrhage. *Referral offered during event. (Code 4004). Care plan documented in clinical records.*
- Obesity BMI>35*. Referral offered in the ante natal period. (Code 4017). Care plan documented in clinical records*
- Macrosomia. *Referral offered in the ante natal period. (Code 4013). Care plan documented in clinical records.*
- Coagulopathies including anaemia. HB<90g/*l Referral offered in the ante natal period (Code 1034). Care plan documented in clinical records.*
- Pyrexia/infection during labour >38 degrees. *Referral in labour (Code 5024). Care plan documented in clinical records.*
- Retained placenta *Referral during the event (Code 6004).*
- Shoulder dystocia *Emergency referral during the event. (Code 5025).*
- Elective C/S
- Low Lying Placenta

(Thorogood, 2015 & Ministry of Health, 2012).

Risk Assessment in the Antenatal period

- Women with known antenatal risk factors should have a well-documented care plan. Practitioners should follow the guidelines as per Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000, and refer women for consultation as appropriate.
- Women known to be at high risk of bleeding should be encouraged to birth in centres with facilities for blood transfusion, intensive care and other interventions and plans should be made in advance for their management (Thorogood, 2015).
- To identify and appropriately treat iron deficiency anaemia See MATY100a
- Women with a suspected abnormal adherent placenta to have a clear management plan and appropriate place of birth documented in their clinical records.

New Information

- Clinicians should consider the use of intravenous tranexamic acid 1000mgs, in addition to oxytocin, at caesarean section to reduce blood loss in women at increased risk of PPH.
  Clinicians should consider the use of intravenous tranexamic acid 1000mgs, in addition to oxytocin in the event of a postpartum haemorrhage (RCOG, 2016; WOMAN Trial Collaborators, 2017)

Women at risk of PPH should have active management of the third stage of labour.
(Elbourne, Prendiville, Carroli, Wood, & McDonald, 2004).

PPH Causes

Tone (80%)

- Atony is the most common cause of PPH. If after administration of oxytocic drugs, tone cannot be maintained then bimanual uterine compression should be attempted.

Trauma (10%)

- Cervical and vaginal lacerations and haematoma. Repair as able, may require EUA. Consider vaginal pack/applying pressure until suturing capability.
- Uterine inversion
- Uterine rupture

Tissue (9%)

- Examine the placenta for completeness
- If not delivered - think retained or invasive placenta. Enlist obstetric support.
- May require EUA

Thrombin (1%).
Refer to haematologist
The advice of a consultant haematologist should be sought to assist in the management of coagulopathy. The most appropriate blood product replacement is dependent on the result of coagulation tests and full blood count and may involve cryoprecipitates, fresh frozen plasma and platelets.

(Draycott, Winter, Crofts & Barnfield, 2013).

Management of Postpartum Haemorrhage
See Appendix 1

Documentation

- Retrospective documentation is required from practitioners involved as close as possible to the time that the events occurred.
- A full accurate contemporaneous description of events is documented in the body of the notes.
- During the crisis phase one practitioner is allocated to take responsibility for documentation.

- Check drugs and IV fluids administered are prescribed on the woman's medication chart.
- All blood products prescribed and administered are documented on the Blood product transfusion record form and Hutt Valley DHB request for blood products (lab form) and the medication chart.
- Any response or adverse reaction to medication/blood should also be noted.
- Accurate fluid balance is noted using the chart on the back of the MEOWS record.
- Record Respirations, SpO2 Saturations, P, BP, and T on a MEOWS chart. Frequency is dependent on clinical situation.

References

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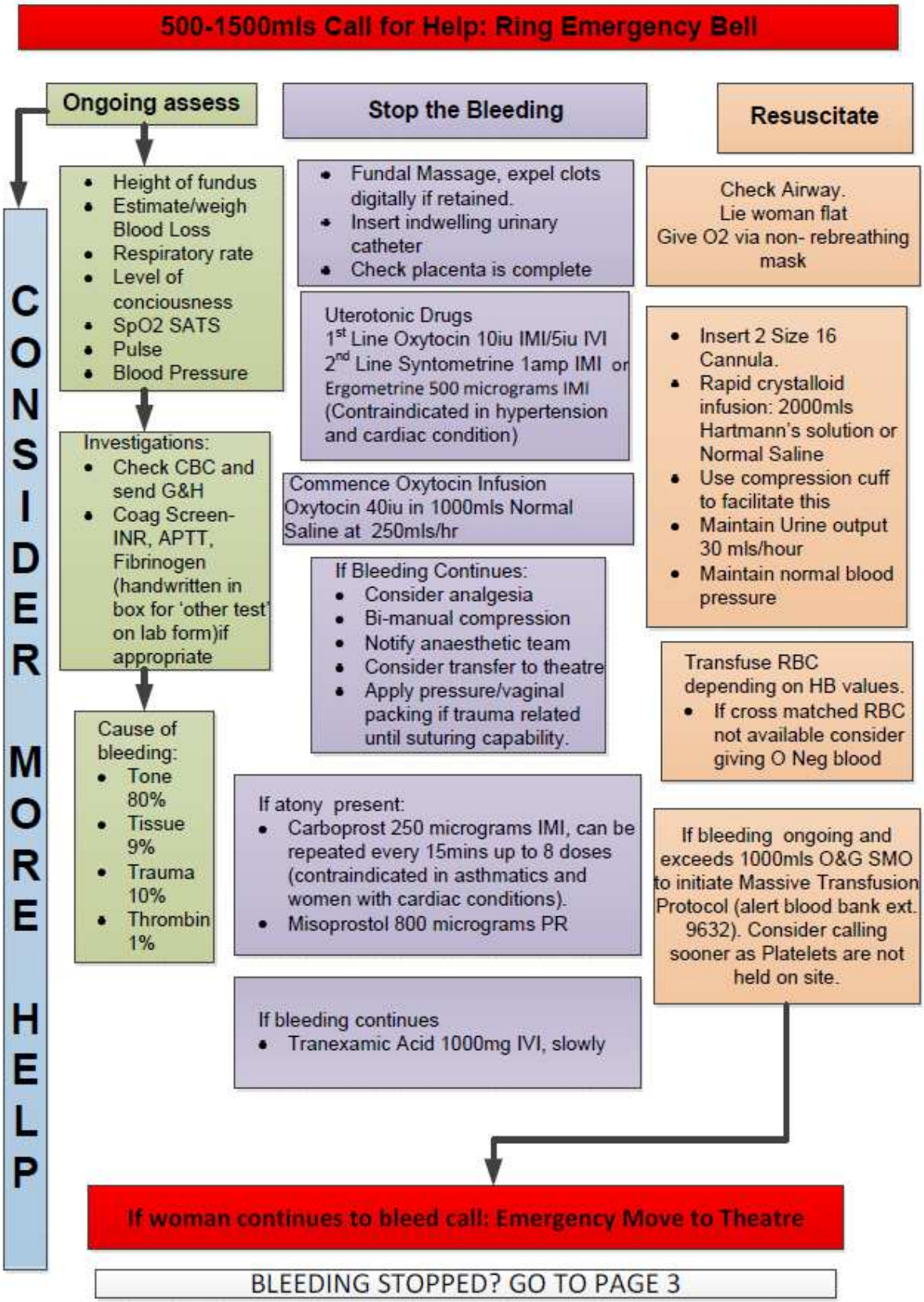
Associated documents/policies

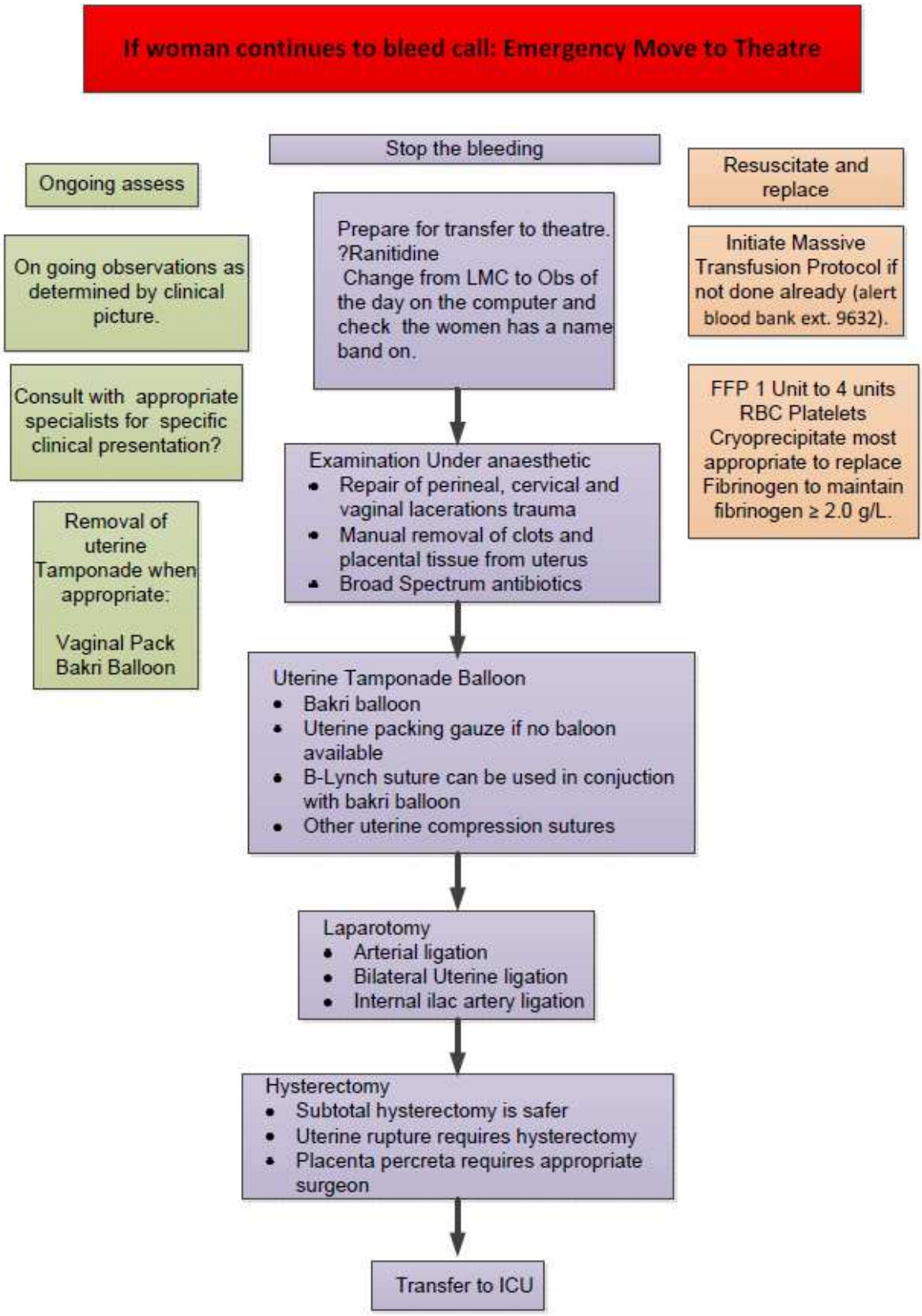
Labour induction guidelines
Third Stage active management guideline
Third stage: Physiological management guideline.
Summoning emergency assistance to the maternity unit

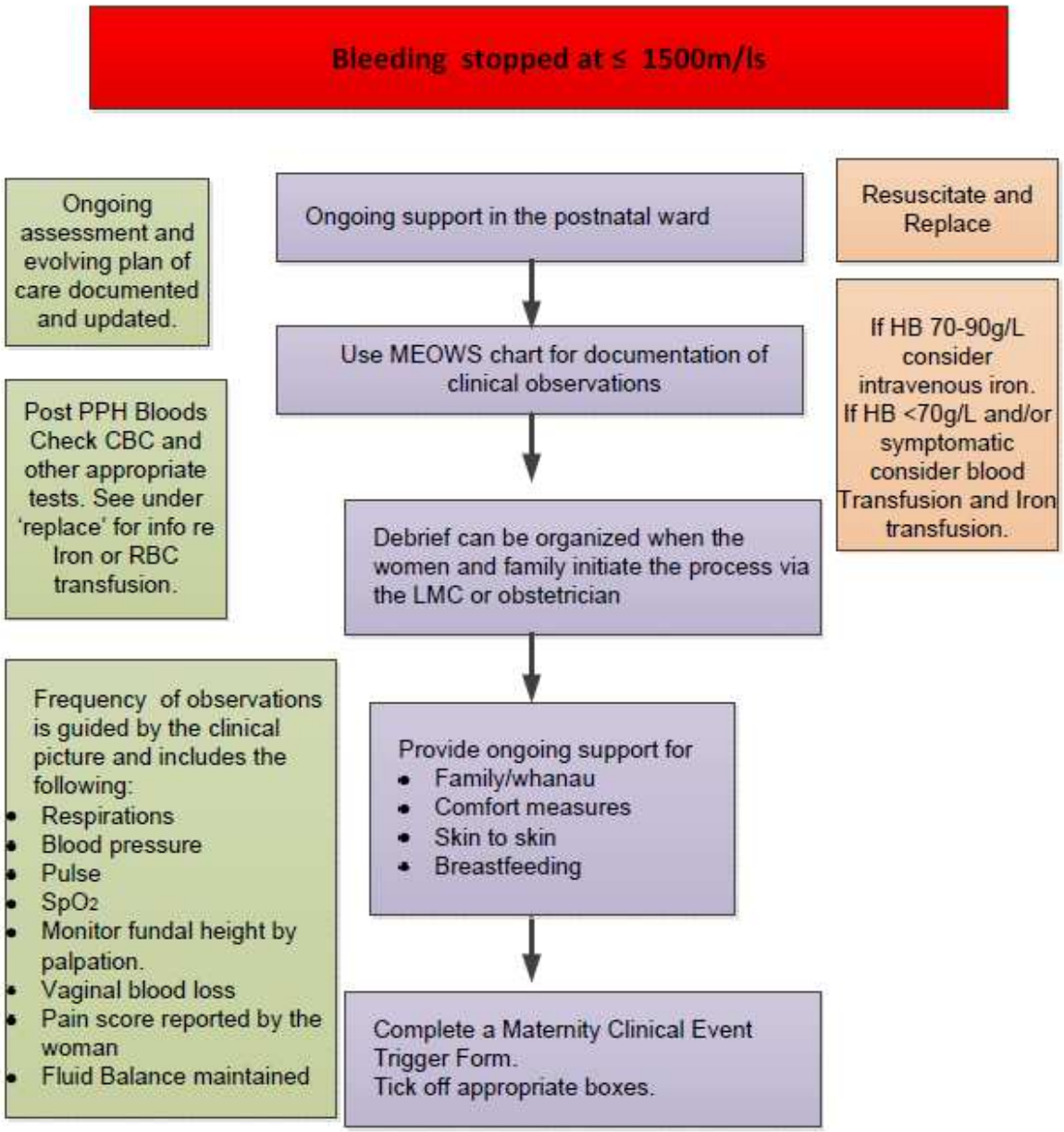
Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

Appendix 1
PPH initial management sheet




If woman continues to bleed call: Emergency Move to Theatre
Stop the bleeding
Ongoing assess
Resuscitate and replace
Prepare for transfer to theatre. ?Ranitidine Change from LMC to Obs of the day on the computer and check the women has a name band on.
On going observations as determined by clinical picture.
Initiate Massive Transfusion Protocol if not done already (alert blood bank ext. 9632).
Consult with appropriate specialists for specific clinical presentation?
FFP 1 Unit to 4 units RBC Platelets Cryoprecipitate most appropriate to replace Fibrinogen to maintain fibrinogen ≥ 2.0 g/L.
Examination Under anaesthetic
Repair of perineal, cervical and vaginal lacerations trauma
Manual removal of clots and placental tissue from uterus
Broad Spectrum antibiotics
Removal of uterine Tamponade when appropriate:
Vaginal Pack
Bakri Balloon
Uterine Tamponade Balloon
Bakri balloon
Uterine packing gauze if no baloon available
B-Lynch suture can be used in conjuction with bakri balloon
Other uterine compression sutures
Laparotomy
Arterial ligation
Bilateral Uterine ligation
Internal ilac artery ligation
Hysterectomy
Subtotal hysterectomy is safer
Uterine rupture requires hysterectomy
Placenta percreta requires appropriate surgeon
Transfer to ICU


Bleeding stopped at ≤ 1500m/ls
Ongoing assessment and evolving plan of care documented and updated.
Ongoing support in the postnatal ward
Resuscitate and Replace
Use MEOWS chart for documentation of clinical observations
If HB 70-90g/L consider intravenous iron. If HB <70g/L and/or symptomatic consider blood Transfusion and Iron transfusion.
Post PPH Bloods Check CBC and other appropriate tests. See under 'replace' for info re Iron or RBC transfusion.
Debrief can be organized when the women and family initiate the process via the LMC or obstetrician
Frequency of observations is guided by the clinical picture and includes the following:
Respirations
Blood pressure
Pulse
SpO2
Monitor fundal height by palpation.
Vaginal blood loss
Pain score reported by the woman
Fluid Balance maintained
Provide ongoing support for
Family/whanau
Comfort measures
Skin to skin
Breastfeeding
Complete a Maternity Clinical Event Trigger Form.
Tick off appropriate boxes.